

Time to let the patient speak

J N Blau

"Listen to the complaint of the patient, however tiresome or irrelevant that may seem. He will eventually tell you what is the matter with him. . . . It is usually better in terms of both care and time to allow the flow to come to a natural halt from exhaustion of either the speaker or the material."¹ The first half of this advice (from an experienced advocate and judge in medico-legal cases and a health service commissioner) is part of the oral tradition of medical practice. But how long is the time of flow to a natural halt? Two years ago I wrote that few patients, if uninterrupted, talk for longer than two to three minutes² and carried out an experiment to support this contention.

Patients, methods, and results

I saw 100 consecutive patients referred by letter from their family practitioners in NHS clinics at the National Hospitals, Queen Square and Maida Vale (25 patients), in the neurological clinic at Northwick Park Hospital (25), at the City of London Migraine Clinic (25), or in private practice (25). Patients whose native tongue was not English were excluded.

Having read the doctor's letter, I asked each patient, "Tell me about your headaches" (or "blackouts" or the major symptom indicated in the referral letter). While the patient spoke I wrote some notes, looked at the patient for some of the time, giving a nod of understanding when appropriate, but at no point interrupted. My wrist watch, propped up at the base of the telephone or other object on the desk and not visible to the patient, gave the time of spontaneous speech, which was noted to the nearest five seconds (table).

The end of the patient's account was indicated by cessation of speech, a look on the patient's face, or concluding statements such as, "That's all I have to say" or "What else can I say?" A few brought notes that they consulted while speaking or, more commonly, when they had finished.

Number of patients seen and length of uninterrupted speaking

	Minutes							Average time
	<1	2	3	4	5	6	7	
Northwick Park Hospital	16	6		2	1			1 m in 10 s
National Hospitals	9	7	4	3	2			1 m in 45 s
Migraine clinic	10	7	4		2	2		1 m in 50 s
Private practice	7	8	3	3		2	2	2 m in 10 s
Total	42	28	11	8	5	4	2	1 m in 40 s

Comment

Seventy per cent of patients spoke for two minutes or less, and the overall average was less than two minutes. This brevity with which patients described their symptoms was surprising. It should not have been: on the BBC's *Just a Minute* programme contestants had difficulty in speaking for 60 seconds without hesitation, deviation, or repetition. Patients who spoke longest had had experience in talking at length or in public; they included a teacher, a welfare officer, a policeman, a saleswoman, and a man who had had psychotherapy for 30 years. Even when discursive speakers were included the overall time was less than two minutes; thus in an average clinic of five or six new patients those who are brief compensate for the few who go on at length.

Writing brief notes is essential for reference and

prevents the doctor staring at the patient. I had a chief whose steely gaze over half moon spectacles stopped the most inveterate talkers, and I have also seen doctors so busy writing that they appeared more like stenographers than sympathetic listeners. This study shows that consultants can let patients speak, listen to all that they have to say, and take the history to complete the picture. Then patients cannot claim that "doctors don't listen," an all too frequent remark heard socially or from relatives grumbling that medical practitioners give an impression of hurry and harassment.

Outside this experiment I usually interrupt patients who repeat themselves, gently pointing out that they have said that before and that I have written it down. If they begin to relate a dialogue: "I said to him . . . and he said to me . . ." I ask for their symptoms, which I need first.

Problems arise when the patient's spouse or parents accompany the patient. The longest consultations occur when the history has to be taken through an interpreter, particularly if the interpreter does more than merely translate questions and answers. These problems are dealt with elsewhere.² Secondary or tertiary referrals can also be lengthy, although few patients take longer than five minutes to relate their experiences.

What I have said applies to consultant practice. Does it apply to general practice, too? I suspect that patients in general practice take even less time to describe their symptoms. Perhaps someone will do this experiment and prove me right—or wrong.

1 Clothier C. *The patient's dilemma*. London: Nuffield Provincial Hospitals Trust, 1988.

2 Blau JN. Headache: history, examination, differential diagnosis and special investigations. In: Rose FC, ed. *Handbook of clinical neurology*. Vol 4. Headache. Amsterdam: Elsevier Science, 1986:43-58.

ANY QUESTIONS

Does cimetidine affect cholesterol concentrations?

Several studies have shown small but statistically significant increases in high density lipoprotein cholesterol concentrations in normolipidaemic subjects given cimetidine 0.8-1.0 g daily. Increases have been in the high density lipoprotein 2 subfraction in most studies, with an increase in high density lipoprotein 3 in some.^{1,2} One patient with familial type III hyperlipoproteinaemia had a more than twofold increase in high density lipoprotein cholesterol concentration when treated with cimetidine 1 g daily.³ The mechanism of this effect is unknown. It is probably not due to H₂ antagonism because it does not occur with ranitidine. Cimetidine differs from ranitidine in that it inhibits hepatic microsomal enzymes, but there is no evidence that these play a part in catabolism of high density lipoprotein. It has been suggested that the anti-androgenic effect of cimetidine may be responsible as there is evidence that androgens can lower high density lipoprotein cholesterol concentrations.³—LINDA BEELEY, director, Drug and Therapeutics Unit, Birmingham

1 Wilson JA, Craig IF. Effects of cimetidine and ranitidine on high density lipoprotein cholesterol concentration. *Br Med J* 1985;290:807-8.

2 Howden CW, Fletcher CD, Farish McBE, Reid JL. Effects of ranitidine and cimetidine on plasma lipoprotein in healthy subjects. *J Clin Pharmacol* 1986;26:97-9.

3 Miller NE, Lewis B. Cimetidine and HDL cholesterol. *Lancet* 1983;ii:529-30.

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